IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 5276

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Peter Trimbos[1]
Date of birth:	30 May 1968
Date of death:	24 September 2020
Cause of death:	1(a) Head injuries
Place of death:	Willison Train Station, Shalless Drive, Camberwell, Victoria

[1] This Finding has been de-identified to protect the identity of the deceased's family members.

INTRODUCTION

1. On 24 September 2020, Peter Trimbos was 52 years old when he took his own life. At the time of his death, Mr Trimbos lived in Victoria with his family.

THE CORONIAL INVESTIGATION

2. Mr Trimbos's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury.

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Trimbos's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into Mr Trimbos's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

[2] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

7. On 25 September 2020, Peter Trimbos, born 30 May 1968, was visually identified by his wife.

8. Identity is not in dispute and requires no further investigation.

Medical cause of death

9. Forensic Pathologist, Dr Joanna Glengarry, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 25 September 2020 and provided a written report of her findings dated 28 September 2020.

10. The post-mortem examination revealed significant head injuries.

11. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

12. Dr Glengarry provided an opinion that the medical cause of death was *"1(a) Head injuries"*.

13. I accept Dr Glengarry's opinion.

Circumstances in which the death occurred

14. At the time of his death, Mr Trimbos had worked as a lawyer for approximately 20 years, having started his own firm, which specialised in costs consulting.

15. In the months leading to his death, Mr Trimbos faced what can only be described as overwhelming stress. He lost both of his parents and father-in-law to COVID-19 and became embroiled in a protracted and widely publicised legal proceeding. There is no need for me to detail the intricacies of those proceedings here, but I will provide a brief summary to illustrate the stressors affecting Mr Trimbos at the time of his death.

16. In 2018, a class action by investors against Banksia Securities settled for $64 million. Mr Trimbos had been retained by Mark Elliott, managing director of Elliott Legal (which had run the class action), and Australian Funding Partners (of which Mr Elliott was also the managing director and which had funded the class action). The purpose of Mr Trimbos's role was to prepare reports regarding the reasonableness of the legal costs incurred by Australian Funding Partners and others, and he subsequently provided several reports between 2016 and

2020. The fees charged became an issue and the Supreme Court appointed a contradictor to review the fees and the conduct of Mr Elliott and others who had worked on the class action. Mr Trimbos's reports and his conduct in preparing them were closely scrutinised, he was required to provide evidence, and he was later joined as a defendant in the proceedings. During the proceedings, it became apparent that Mr Trimbos had been misled regarding the true costs incurred, which had affected the accuracy of his reports.

17. In June 2020, Mr Trimbos attempted to take his own life by cutting his wrists. He was taken to Box Hill Hospital where he was assessed and discharged after three days. His wife stated this was the first time Mr Trimbos demonstrated suicidal thoughts or ideation.

18. After leaving hospital, Mr Trimbos consulted his general practitioner, Dr Richard Hince at Camberwell Junction Medical Clinic, and a mental health plan was put in place. He was subsequently referred to a psychologist, who he saw twice. He reported being under significant psychological distress but declined to attend further consultations with the psychologist.

19. From late July until mid-August 2020, Mr Trimbos endured the death of his parents and father-in-law. His wife stated that the loss of his mother weighed most heavily. A week later, he was called to give evidence in the Banksia Securities proceeding.

20. On 20 August 2020, Mr Trimbos was formally joined as a defendant to the Banksia Securities matter, and on 21 September 2020 he filed an affidavit setting out his conduct with respect to the proceedings and provided context to his reports. Mr Trimbos's wife described the increased scrutiny as her husband's worst nightmare.

21. On 23 September 2020, Mr Trimbos appeared to be in good spirits – he went shopping and made dinner and celebrated his daughter's success at school. Mr Trimbos's wife stated that later that evening, her husband received an email regarding the proceeding, which visibly distressed him, but he told her not to worry.

22. During the early hours of 24 September 2020, and while his wife was getting ready for the day, Mr Trimbos arranged three pillows on his side of the bed and pulled up the covers. He thereafter made his way to Willison Train Station, Camberwell. He accessed the railway tracks, placed his personal items on a concrete support under the station platform, and laid down on the tracks. It appears that a passing train then made contact with Mr Trimbos, which caused fatal injuries.

23. The train driver was unaware of the incident and did not report it. At approximately 5.50am, a train driver travelling on the following train observed the body, stopped the train, and reported the incident. Emergency services were contacted, and paramedics confirmed Mr Trimbos's death a short time later. Shortly thereafter, Mr Trimbos's wife went for her usual bike ride and saw emergency services at the train station. After returning home to find the pillows in the bed, she returned to the train station where police confirmed her husband was deceased.

24. In her statement, Mr Trimbos's wife stated that while her husband was affected by the death of his parents, it was the legal proceeding that caused Mr Trimbos to take his own life as he feared he would be implicated and face adverse consequences, despite having done nothing wrong. She described her husband as being crippled by the stress and he was worried they would lose the house. She explained that the mission to clear his name consumed him and it was difficult to tell whether he was starting to withdraw from his family or whether he was simply preoccupied with work.

25. Late last year Justice John Dixon handed down a decision that found that Mr Elliott and others had engaged in unconscionable conduct and deliberately misled the court regarding the legal fees incurred in the Banskia Securities class action. However, his Honour also found that Mr Trimbos had not acted independently in assessing the costs purportedly incurred and his reports also misled the Court.[3] Mr Trimbos's conduct allowed Australian Funding Partners's illegitimate claim to succeed undetected. Justice Dixon found that Mr Trimbos failed to act as an independent expert witness and did not make proper enquiries concerning how legal costs had been calculated or to confirm they were referable to work actually performed.[4]

26. I am satisfied that at the time of his death, Mr Trimbos's mental health was affected by ongoing proceedings regarding his conduct in the Banksia Securities proceeding, which may have included a recognition or suspicion that his career and reputation would suffer irreparable damage and the possibility that he would be liable to pay significant damages. The same litigation was a significant factor in the death of another lawyer involved with the case.

[3] Bolitho v Banksia Securities Ltd (No 18) (remitter) [2021] VSC 666.
[4] Supreme Court of Victoria, Summary of Judgment, *Bolitho v Banksia Securities Ltd (No 18) (remitter)* [2021] VSC 666, 11 October 2021.

FINDINGS AND CONCLUSION

27. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the deceased was Peter Trimbos, born 30 May 1968;

    (b) the death occurred on 24 September 2020 at Willison Train Station, Shalless Drive, Camberwell, Victoria, from head injuries; and

    (c) the death occurred in the circumstances described above.

28. Having considered all of the evidence, I am satisfied that Mr Trimbos intentionally took his own life.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

Victorian Suicide Register

1. The Victorian Suicide Register (**VSR**) is a database containing detailed information on suicides that have been reported to and investigated by Victorian Coroners between 1 January 2000 and the present.

2. The VSR indicates the annual frequency of suicides occurring in the state of Victoria has been steadily increasing for the past decade, from 550 deaths in 2011 to a peak of 731 deaths in 2020.[5]

3. The annual Victorian suicide rate for the period 2011 to 2019 ranged from 9.9 suicides per 100,000 people in 2011 to 11.0 suicides per 100,000 people in 2017.[6]

[5] Coroners Court Monthly Suicide Data report, November 2021 update. Published 22 December 2021.
[6] The annual suicide rate is the annual suicide frequency expressed as a proportion of the population in which the suicides occurred. The most common calculation for a crude rate is to divide the frequency of Victorian suicides by the overall population of Victoria in that year, then multiple by 100,000 (to produce the suicide rate per 100,000 people). For example, in 2011 there were 550 Victorian suicides and the population of Victoria at that time was estimated to be 5,537,817 people, so the rate was (550 ÷ 5,537,817) × 100,000 = 9.9 suicides per 100,000 people.

4. I note that the Coroners Prevention Unit[7] has identified 25 suicides of legal professionals in Victoria between 2011 and 2021.[8] This comprised of 15 males (60.0%) and 10 females (40.0%). The highest proportion of suicides were reported among those aged between 45 to 54 years with 10 suicides (40.0%). This was followed by the 55 to 64 group with nine suicides (36.0%), all of whom were males.

5. The primary purpose of gathering suicide data in the VSR is to assist Coroners with prevention-oriented aspects of their suicide death investigations. VSR data is often used to contextualise an individual suicide with respect to other similar suicides; this can generate insights into broader patterns and trends and themes not immediately apparent from the individual death, which in turn can lead to recommendations to reduce the risk that further such suicides will occur in the future.

6. So much is still unknown about suicide and every suicide occurs in unique circumstances to a person's history and life experience. Through recording information about each individual suicide in the VSR, particularly information about the health and other services with whom the person had contact, and then looking at what has happened across time and across people, the data collected by the VSR can lead to new understandings of how people who are suicidal might better be supported in our community.

I convey my sincere condolences to Mr Trimbos's family for their loss.

I am satisfied publication of this finding is in the public interest. Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

[7] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[8] 2021 is year-to-date frequency to 30 September.

I direct that a copy of this finding be provided to the following:

Senior next of kin

Senior Constable Nicholas D'Eramo, Victoria Police, Coroner's Investigator

Signature:

Caitlin English, Deputy State Coroner

Date: 24 February 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.